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Vision Therapy Assessment Referral

Today's Date: _____

Patient Name: _____

Referring Professional: _____

D.O.B: _____

Tel: _____

Address: _____

Fax: _____

Tel: _____

Email: _____

REASON FOR REFERRAL: (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Strabismus | <input type="checkbox"/> Eye Tracking/Oculomotor | <input type="checkbox"/> Perceptual Evaluation |
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Accommodative Dysfunction | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Difficulty at school | <input type="checkbox"/> Binocular Dysfunction | <input type="checkbox"/> TBI / ABI |
| <input type="checkbox"/> Reading concerns | <input type="checkbox"/> Difficulty at School | <input type="checkbox"/> Sports Vision Evaluation |
| <input type="checkbox"/> Other: _____ | | |

Refraction OD: _____ 20/

Refraction OS: _____ 20/

Cycloplegic OD: _____ 20/

Cycloplegic OS: _____ 20/

Has ocular health been assessed? Yes No

What were the findings of the ocular health assessment? _____

COMMENTS/RELEVANT EXAMINATION RESULTS: _____

Please Fax this form to 905-875-5468

Our office will contact the patient to book an appointment

Once the patient has completed their assessment a copy of their report will be faxed to your office